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ABSTRACT

This collection of handouts is designed to accompany a 2-hour videotape on assessment strategies for American Indian vocational rehabilitation clients. The videotape covers what assessment is, who should be referred for assessment, types of assessment, types of referrals (psychological, vocational, and educational), and how report findings can be fully utilized. The handouts include a multiple-choice quiz, an outline of the videotape content, critical factors to consider in the vocational evaluation process, overview of some common disability traits, vocational assessment devices useful with American Indian clients, diagnosis of psychological disorders, and a paper by Kevin Horan and Daniel C. Cady from the "Arizona Counseling Journal" titled "The Psychological Evaluation of American Indians." (JDD)

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Presentation outline to accompany the Videotape:

Assessment Strategies for American Indian Vocational Rehabilitation Clients

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Handout 1
Outline of Presentation

I. What is assessment? How is it useful?

II. Who should I refer and for what type of evaluation?

III. Types of assessment:

- A. Initial Counselor Interview
- B. Medical
- C. Psychological
- D. Vocational
- E. Education, family, and cultural

IV. What type of referrals are useful?

- A. Psychological
- B. Vocational
- C. Educational

V. How do I fully utilize my report findings?

HANDOUT 2

QUIZ

1. Probably the most important psychological evaluation procedure is:

   A. *Wechsler Intelligence Test - Revised*

   B. *MMPI - 2*

   C. Clinical Interview

   D. *WRAT - R*

2. If an American Indian rehabilitation client has a *WAIS-R* verbal IQ of 65, he/she is most likely:

   A. Mildly Mentally Retarded

   B. Brain Injured

   C. Borderline Cognitive Level

   D. None of the Above

3. A good non-reading vocational interest test for very low reading ability clients is:

   A. *Career Assessment Inventory*

   B. *Wide Range Interest and Opinion Test*

   C. *Self-Directed Search*

   D. *Strong Campbell Interest Inventory*

4. A very important vocational aptitude test for more traditional American Indian clients is:

   A. *The Differential Aptitude Test*

   B. *The General Aptitude Test Battery*

   C. *Work Samples*

   D. *Bennett Mechanical Comprehension Test*

5. Neuropsychological evaluation procedures are usually appropriate for:

   A. Motorcycle Accident Client

   B. Epilepsy Client

   C. Gun shot to head client

   D. All of the above

6. A good vocational evaluation will provide information about:

   A. Amount of structural brain damage

   B. Brain behavioral relationships of a client

   C. Number of seizures a client may have

   D. How to assist/compensate for individual academic and work related problems

7. A person who was recently head injured in a truck accident (4 weeks ago) is a good referral for the following type of evaluation:

   A. Psychological

   B. Vocational

   C. Neuropsychological

   D. None of the above

8. The most common type of hallucination in a schizophrenic American Indian client is:

   A. Visual

   B. Tactile

   C. Auditory

   D. Olfactory

9. An American Indian client who is 45 years old and just had their first psychotic break (Schizophrenia Symptom) has a better vocational prognosis than a 30 year old chronically/mentally ill (SMI since 18 years of age) stabilized client:

   A. True

   B. False

   C. Can't say

10. A person who is unreliable, lacks remorse or sadness for his actions, is very self-centered as well as charming/manipulative with average to above average cognitive level may have a:

    A. Schizoid Personality

    B. Anti-Social Personality

    C. Passive Aggressive Personality

    D. Dependent Personality

11. Good vocational evaluations usually:

    A. Provide all needed information to work with a client

    B. Take about 20 days to complete testing

    C. Are able to provide information related to aptitudes, interests and academics

    D. Provide a diagnosis of emotional disorders

12. A person who is very impulsive in areas that are self-damaging (substance abuse - spending money) and has recurrent suicidal threats or gestures and inappropriate intense anger may have a:

    A. Paranoid Personality Disorder

    B. Histrionic Personality Disorder

    C. Avoidant Personality Disorder

    D. Borderline Personality Disorder

13. A Post-Traumatic Stress Disorder is:

    A. Only found in war veterans

    B. Is a very rare mental condition

    C. Never seen in children

    D. A serious anxiety disorder

14. A 19 year old American Indian drop-out with a performance IQ of 70 is given a diagnosis of learning disability by a school Psychologist, the best thing to do in rehabilitation planning would be to:

    A. Follow the school Psychologist's recommendations

    B. Ignore the evaluation and re-evaluate

    C. Send to adult educational courses

    D. Not feasible for rehabilitation

15. A family comes to the rehabilitation counselor's office to go over their 20 year old daughter's evaluation results. The daughter is not with them. The best thing to do is:

    A. Quick go over their results verbally

    B. Let them review the report from the file themselves

    C. Refuse to discuss details of the evaluation

    D. Have the daughter give them verbal permission to see her test results

HANDOUT 3
DEFINITION OF ASSESSMENT

I. Definition of assessment

To estimate the value of, etc.
To set or determine an amount of, etc.
To find an individual's strengths and limits

II. Why is an evaluation or assessment necessary?

A. Clarify client's abilities - try to confirm what they say;
B. Determine vocational interests - realistic or not;
C. Discover hidden talents;
D. Make sure future training placement is not too hard or too easy;
E. Look for areas that may need remediation;
F. Help client with self-discovery;
G. Make realistic and financially sound choices for client's placement;
H. Clarify any suspected emotional concerns;
I. Clarify any neurological condition and its impact on daily living;
J. Clarify medical status and understand physical limits;
K. Provide needed information from unbiased perspective;
L. Document current status for future reference.

III. A Counselor's Initial Evaluation

Basic Demographics: Name, Age, Address, Family
Primary Language:
Transportation:
Vocational History: (length of jobs)
Educational History:
Type of disability - functional limitations:
Medical status:
Treatment:
Medications:
Restrictions:
Appearance:
Behavior:
Motivation:
Time awareness:
Steps to determine eligibility:
General Medical Examination:
Specialist:
Psychological
Neuropsychological
Vocational Evaluation

IV. General Medical Examination

A. Basic Physical Exam

1. Self-report
2. General physical condition
3. Lab work-up
4. Limitations
5. Recommendations

B. Referring to Specialists, if necessary

V. Psychological Evaluation

A. Provide information on:

1. Cognitive status
2. Style of learning
3. Emotional/social status

B. Breakdown of factors

1. Cognitive ability

a. Superior
b. Bright/average
c. Average
d. Low/average
e. Borderline
f. Mild MR
g. Moderate MR
h. Severe MR

2. Style of Learning

a. Visual
b. Auditory
c. Tactile
d. Combinations

3. Emotional Status

   a. Major Clinical Syndromes

      i. Depression
      ii. Schizophrenia
      iii. Bipolar disorder
      iv. Dementia
      v. Substance abuse
      vi. Anxiety and adjustment disorders
      vii. Sexual problems

   b. Personality Disorders

      i. Paranoid - Schizoid - Schizotypal
      ii. Dependent/Passive
      iii. Anti-Social

VI. Vocational Evaluation Strategies

A. Work samples
B. Dexterity tests
C. Aptitude tests
D. Academic tests
E. Interest tests - Holland Classification
   1. Reading
   2. Non-reading
F. Self-disclosure procedures
   (Transferable Skills Interview)
G. Direct on-the-job observation
H. Other techniques

VII. Referral for Psychological Evaluation

A. Suspected substance abuse:
Physical condition
Facial appearance
Smell ETOH (alcohol)
Inconsistency in response
Dull response
Anxious
Tremor
Past history
Counselor impression

B. Suspected Depression:
Sad mood
Short responses
Crying
Flat affect
Slow motor response
Little energy
Possible suicidal thoughts
Family confirmation
Isolation
Decline in daily activities

C. Suspected Mental Illness
Unusual responses
Strange behavior
Decline in appearance
Abrupt changes in activities
Hallucinations
Delusions
Family responses
Legal trouble

D. Suspected Neurological Injury
Specific events
Memory problems
Regression in activity
Poor decision making
Paralysis/hand tremor
Visual problems
Speech problems
Reception - expression
Family indications

E. Suspected Mental Retardation
Slow response
Family history
Facial appearance
Motor activity
Eyes
Verbal ability
Past educational history

F. Suspected PTSD (Post-traumatic Stress Disorder) or Adjustment Disorders
Nervous
Tremors
ETOH (alcohol)
Military history
Significant life event
Isolation
Family report
Poor work history
Much travel (not settling down)

Refferal Questions

How to formulate relevant referral questions

Questions for the following factors:

Physical

Cognitive

Emotional

Neurological

Location

Education

Other (e.g., Legal)

How to use Report Findings

HANDOUT 4

CRITICAL FACTORS TO CONSIDER IN THE VOCATIONAL EVALUATION PROCESS

I. How general factors as well as functional limitations affect the evaluation process and modify findings.

Non-Indian Specific	Indian Specific
Sensory Impairments	Time Factors
Cognitive Deficiency	Knowledge of Assessment Process/ Preorientation
Medication	Anglo-Indian Rapport
Orthopedic Problems/ Limitations	Academic Proficiency
Psychological Status	Work History
Motivation	Off-Reservation Survival
Alcohol/Drugs	Client Priorities
	Cultural Factors

II. Hands-on versus paper/pencil testing.

III. Importance of transferable skills interview.

IV. Knowledge of narrow versus wide-band vocational interests.

V. Feedback during evaluation.

VI. Utilization of referral questions during evaluation.

HANDOUT 5

OVERVIEW OF SOME COMMON DISABILITY TRAITS

Back Injury

Chronic Back Pain
Restricted Movement
Irritability
Frustration
Poor attention span
Depression

Vocational Aptitudes

Upper extremity dexterity
Fine motor skills
Spatial/nonverbal perceptual skills
Transferable skills
Hands-on areas
Technical knowledge of tools/machinery

Alcohol/drug abuse or dependence

Cognitive dullness proportionate to length of abuse
Poor memory
Flat aptitude profiles
Frequent failure to cooperate
Frequent relapses
Personality disorders
Legal record

Vocational aptitudes noticed

Good social skills
Verbal abilities
Underestimate vocational aptitudes due to condition/attitude
High intelligence-limited insight

Chronic Mental Illness

Above average to superior intelligence (often mistaken , however, as mentally handicapped)
Poor social skills
Strong need for affiliation
Poor appearance
Noncompliance/inconsistency in medication
Oftentimes inappropriate diagnosis (atypical versus schizophrenia)
Past suicidal attempts/gestures
Legal record
Spiritual/ceremonials

Vocational aptitudes

Frequent repetitive low-level hands-on skills
Outdoor aptitudes
College/technical training

Learning Disability

Spatially competent learning disabled
Limited linguistic skills
Limited motivation in school/post grammar/high school training
Poor past experiences limited vocational training
Incorrect teaching methods
Excellent realistic hands-on skills

Vocational aptitudes

Machine operation
Factory
Maintenance
Driving jobs
Significant discrepancy in verbal versus spatial performance

Mild Mental Retardation

Often misdiagnosed
Data misrepresented in reports
Lack of vocational aptitude assessment
Physical appearance compromised
Dependency
Undersocialization

Vocational aptitudes

Non-paper/pencil proficiency
Hands-on work sample aptitudes
Manual dexterity
Tendency toward repetitive jobs
Simple sorting/classification
Janitorial skills
Landscaping skills
Visual hands-on demonstrations

Epilepsy

Possible cognitive dullness
Anticonvulsant medication effect
Memory problems
Possible personality disorder (e.g., avoidant/aggressive)
Little family contact
Misunderstanding regarding disability

Vocational aptitudes

Possible normal vocational aptitude profile
Strong nonverbal strengths
Vocational choices noncompatible with disability
Low academics
Poor following of directions

HANDOUT 6

VOCATIONAL ASSESSMENT DEVICES USEFUL WITH AMERICAN INDIAN CLIENTS

Achievement tests

Name of test: Wide Range Achievement Test-Revised

Areas Measured: Reading recognition, Mathematical computation, Spelling.

Comments: Good quick screening for arithmetic ability. Some reading recognition and spelling words inappropriate for Indian clients (underestimate of reading/spelling ability).

Name of test: Nelson Reading Test

Areas Measured: Reading Vocabulary/Comprehension.

Comments: Timed measures slight underestimate of ability.

Name of test: Industrial Reading Test

Areas Measured: Comprehension of Technical/Written Material.

Comments: Difficult for many Indian and non-Indian clients. Some superior performances noted.

Name of test: Adult Basic Learning Dissemination

Areas Measured: Simple spelling, Mathematics, Reading Vocabulary.

Comments: Fair measure of individuals with limited prior academic training.

Name of test: Informal Writing/Spelling Test

Areas Measured: Nonstandardized behavioral observations of written creative ability.

Comments: Good measure; nonthreatening.

Vocational Interest Tests

Name of test: Career Assessment Inventory/Enhanced Career Inventory

Areas Measured: Assessment of Job Preferences. Likes, Dislikes divided into Holland's categories.

Comments: Major emphasis usually placed on realistic hands-on occupations; good measure for clients with at least fifth-grade reading ability.

Name of test: Strong-Campbell Interest Inventory

Areas Measured: Higher/more technically demanding occupational preferences.

Comments: Fair measure for college-bound or more technical training-based Indian clients.

Name of test: World of Work Inventory

Areas Measured: Wide-range assessment of work values plus occupational preferences.

Comments: Fair measure with Indian clients.

Name of test: Geist Picture Interest Inventory

Areas Measured: Interests

Comments: Good measure for non reading clients and clients with very limited academic proficiency.

Name of test: Wide-Range Interest and Opinion Test

Areas Measured: Vocational intertests and opinions.

Comments: Good measure for Indian rehabilitation clients with limited reading ability. Strong sex stereotype and realistic machine operation indicators; lengthy.

Name of test: Self-Directed Search

Areas Measured: Interests, values

Comments: Fair measure for Indian rehabilitation clients with at least high school education. Good information for vocational interview follow-up.

Name of test: Harrington-O'Shea Career Decision Maker

Areas measured: Vocational interests.

Comments: Presently fair measure or experience required.

Name of test: Career Counselor

Areas Measured: Computer assisted vocational aptitude/interest test.

Comments: Simple immediate feedback with career search; good measure for vocational interests with Indian clients.

Vocational Aptitude Tests

Name of Test: General Aptitude Test Battery (GATB)

Areas Measured: Measurement of general learning ability - verbal, numerical, spatial, form perception, clerical speed and accuracy, and fine/gross motor coordination.

Comments: Tendency to be misinterpreted by inexperienced evaluators, look for discrepancy in math subtest (written versus problem), spatial/form perception subtest usually highest followed by hands-on manual skills (fair measure utilized by the Department of Labor for potential) - Tendency to be used as an exclusionary factor but biased.

Name of test: Valpar Services Vocational Workshop Samples

Areas Measured: Small tools, size discrimination, numerical sorting, upper extremity range of motion, independent problem-solving, multi-level sorting, whole body range of motion, trilevel measurement, eye/hand/foot coordination, soldering and inspection, money handling, circuitry, drafting. Work samples geared toward specific occupational preferences/worker traits.

Comments: Many hands-on work samples utilized in evaluation center have been extremely helpful in evaluating potential; excellent measure of learning ability when used in process, assessment format.

Name of test: Prep Workshop Samples

Areas Measured: Small engine repair, solar technology, electrical, metal construction, wood construction, medical services, commercial art, bookkeeping, communication services, refrigeration, machine trades, computer technology. Over 133 specific transferable skills measured; 194 specific job-related materials.

Comments: Excellent for evaluator's observations, working knowledge of job, learning potential. Note: very expensive, limited utilization; job markets in area should be explored before purchase.

Name of test: Vocational Adaptation Rating Scales

Areas Measured: Measure for Mildly Handicapped in terms of workshop potential/ behavior in a structured setting.

Comments: Excellent measure for use in a sheltered workshop or to document current functional levels and include in IWRP.

Name of test: Training Performance Sample

Areas Measured: Measure utilized to predict rehabilitation costs for severely handicapped.

Comments: Works well with vocational skills training program in order to assess feasibility for occupational success; inexpensive-process assessment format.

Handout 7

Diagnosis of Psychological Disorders

Personality Disorders

I. Paranoid
   A. Expects to be harmed/exploited
   B. Often questions without reason
   C. Interprets simple conversation as having hidden meaning or threats
   D. Reluctant to confide in others

II. Schizoid
   A. Solitary
   B. Little or no sexual experience
   C. No close friends
   D. Constricted affect
   E. Indifferent to praise

III. Anti-Social
   A. Conduct disorder before age 15
   B. Age 18 or older
   C. Lack of respect for social norms and laws
   D. Lack of regard for truth
   E. Aggressive
   F. Fails to plan ahead; impulsive
   G. Reckless regarding safety of self or others
   H. Lacks remorse

IV. Dependent
   A. Poor decision making without help
   B. Often allows others to do things for him
   C. Helpless when alone
   D. Always agrees with others

V. Borderline
   A. Impulsive
   B. Emotionally labile
   C. Manipulative
   D. Intense anger
   E. Recurrent suicidal gestures
   F. No real long-term goals
   G. Chronic boredom or emptiness

POST-TRAUMATIC STRESS DISORDER

I. Event is experienced outside the range of *usual* human experience

II. The event is re-experienced persistently in at least one of the following ways:

   A. Recurrent/Intrusive recollection

   B. Dreams

   C. Sudden feeling event is re-occurring

      1. Illusion

      2. Hallucination

      3. Dissociative (Flashback; often when awakening or intoxicated)

   D. Distress when around events that symbolize or resemble an aspect of the traumatic event

III. Avoidance of stimuli associated with event

IV. Loss of interest in activities

V. Feeling detachment from others; isolation

VI. Inability to have loving feelings for others

VII. Foreshortened career or future

VIII. Increased arousal; anger/startle response

IX. Duration: 1 month; may have delayed onset

SCHIZOPHRENIA

I. Possible Symptoms
   - A. Delusions
   - B. Hallucinations
   - C. Loose associations
   - D. Inappropriate affect

II. Regression in Functioning
   - A. Work
   - B. Self-care
   - C. Social

III. Duration: 6 months or more
   - A. Prodromal phase or residual
     1. Social withdrawal/isolation
     2. Impairment in role functioning
     3. Peculiar behavior
     4. Impairment in personal hygiene
     5. Blunted affect
     6. Unusual speech
     7. Odd beliefs inconsistent with cultural norms
     8. Unusual perceptual experiences
     9. Lack of interest in daily activities

IV. No organic factors

V. Course of disturbance
   - A. Sub-chronic (less than 2 years)
   - B. Chronic (more than 2 years)
   - C. Sub-chronic with acute exacerbation
   - D. Chronic with acute exacerbation
   - E. In remission

VI. Types
   - A. Catatonic
   - B. Disorganized
   - C. Paranoid
   - D. Undifferentiated

The Psychological Evaluation of American Indians

Kevin Horan and Daniel C. Cady

This article contains an outline of strategies, techniques, and cautions which are useful in the psychological evaluation of American Indians.

A somewhat naive Anglo ranch owner was once in the market for a horse. While driving across the Navajo reservation, he saw an older Indian gentleman who was leading a number of horses down the side of the road. Stopping his truck and horse-trailer, he began an impromptu bartering session with the grandfatherly-looking Navajo. The Anglo, noticing a relatively healthy-looking horse, indicated that he was interested in it. The older Navajo smiled but protested selling the horse, claiming that "It don't look good." After much insistence, a deal was finally worked out, cash was exchanged for the animal, and in spite of the transaction, the Navajo continued to insist the horse "did not look good." The Anglo placed the animal in his horse trailer and drove off. After arriving at his ranch, he took his new horse into the corral and attempted to saddle and ride it. The horse, after being mounted by the man, proceeded to stumble into the side of a fence. After falling, dusting himself off, and unsaddling the horse, the disappointed would-be cowboy called the local veterinarian. After a very brief examination, the horse was determined to be blind. Angered, the rancher placed the horse in the trailer and, well above speed limit, returned to the elder Navajo's small corral and hogan. After being subjected to a string of profanities and demands for the return of his money, the elderly Navajo smiled and again responded "I told you the horse don't look good."

A number of important lessons relevant to the psychological evaluation of American Indians are found in this brief story. While much has been written on the negative aspects of standardized testing and evaluation of Indians, not much is written on the need to combine and assimilate a number of critical common sense ideas for a useful and practical evaluation of the psychological status of Indian people. In this article we discuss a number of useful techniques, practical considerations, and some obvious misconceptions that "don't look good" in the process of psychological assessment of American Indians.

Establishment of Rapport

Consideration must be given to a number of factors which need to be addressed prior to, during, and after the process of psychological evaluation. A primary concern is the general purpose of the evaluation procedure. We have found over the course of the last ten years that a basic orientation process, using non-technical language, works very well to break the ice and put an individual at ease prior to testing. A brief description of yourself in terms of personal past experience with Indian clients may be helpful. A

review of a hypothetical case similar to that of the individual being evaluated, if done tactfully, allows for explanation of not only test-taking processes but also outcome and feedback of test results. The examiner should be aware of the ongoing level of rapport and the potential for misunderstanding during the evaluation.

Many Indian clients respond well to humor during the course of testing. Frequent breaks, a cup of coffee, a chance to swap jokes or small talk in a different setting (e.g., a coffee room) also helps to break down anxiety, guardedness, and a perception by the client that the examiner is in an adversarial role. It cannot be emphasized enough that the establishment of sufficient rapport with American Indian clients in the test setting is extremely important and may not come quickly. Efforts to assess a client's readiness and maintain motivation require a considerable degree of sensitivity on the part of the examiner. This comes with experience and awareness of the cultural aspects of the particular tribe or tribes with which one is working.

Testing Procedures

Selection of appropriate non-biased test procedures to use with individual Indian clients is still a much debated topic in the field of assessment. Much research has been conducted in this area, and the reader is referred to *Native American Rehabilitation: A Bibliographic Series, No. 1: Assessment Issues* (Joanne Curry O'Connell, 1986) for an annotated bibliography on this subject. Current assessment devices that we have found useful for the evaluation of American Indians include a number of standardized procedures as well as certain testing to the limits techniques. It should be noted that our experience is with members of the Navajo, Apache, Hopi, Havasupai, Hualapai, and Paiute tribes.

Clinical Interview/Mental Status Examination

One of the most important evaluation procedures with American Indian clients is the Clinical Interview and Mental Status Examination. If proper rapport has been established and environmental concerns addressed (e.g., wear casual clothing - not a suit and tie), much useful information can be derived from a clinical interview. During the interview process it is helpful to go through a hierarchy of questions from least threatening to most clinically significant. In many cultures, the most clinically significant questions will also tend to be the most threatening to the client, including questions about family issues, alcoholic/drug use, sexual matters, medical, and financial issues. It helps to gain a general social history prior to asking more specific clinical questions. More traditional Indian clients often require additional time to respond, and many Anglo examiners need to allow for the use of the "pregnant pause" or gap in response time. Many traditional Indian clients also require additional time to formulate responses in a manner with which they feel at ease. Once the examiner senses that the client trusts the examiner, one can move from the social history gathering to more specific information. It should be noted that social history should take into consideration traditional/ceremonial aspects of the individual clients's early life as well as family concerns.

Specific current complaints should be obtained along with obvious symptoms related to sleep, appetite, depression, suicide, and emotional factors during the mental

status interview. Additional questions which we have found useful address presence and history of head injury, off-reservation work and general living experience, and childhood medical problems. Moving from basic intake questions to a formal mental status examination is often best accomplished in a very casual manner. Include questions related to the client's knowledge of the tribal councilmembers, chairperson or leaders, as well as additional nonpolitical information. For example, when working with more traditional Navajo clients, information is often obtained about chapter house, clan, means of transportation, condition of livestock, weather, and other relevant topics. When conducting mental status exercises we allow the client to count forward and backward in his or her native language, and recall memory words which are relevant to the client's reservation (e.g., hogan, truck, river). An estimate of intellectual level can be made through this type of conversation but must be done very cautiously.

It can also be helpful to arrive at some level of understanding of the humor perception of individual clients. This can be done simply by exchanging a joke with the client. For example, the joke involving the horse that does not "look too good" was given to us by an otherwise somewhat depressed client. Humor also facilitates the transition to more standardized testing such as the *WAIS-R*. Alternating between cognitive and personality assessment techniques during evaluation can help to decrease the intensity of the evaluation process.

Cognitive Assessment

Some of the most useful cognitive assessment devices currently available include the *WAIS-R* performance subtest and the Raven's ***Standard, Coloured, and Advanced Progressive Matrices***. These tests provide a relatively nonbiased measure of nonverbal cognitive operations. The verbal subtest of the *WAIS-R* can be somewhat biased for some Indian clients. For example, many of the general information questions are simply not relevant to reservation life and they may not have been addressed at school. Similarly, social comprehension questions which are scored on quality of response are not culturally relevant to many American Indians. In contrast, the performance scales are relatively nonbiased; however, caution is required when utilizing them. Examples of concerns regarding specific *WAIS—R* subtests follow.

Picture Completion. The visual discrimination necessary for completion of this subtest works well with Indian clients for the most part. There are some concerns, however, on certain pictures. Many more traditional Indian clients say a person is missing from the picture rather than naming the "correct" missing item in the pictures of the boat, the watch, the horse, and the barn. Clarification is often necessary in order to redirect for a more specific item. Also, many traditional clients may not be familiar with some of the pictures (e.g., the crab or the playing card).

Picture Arrangement. The Picture Arrangement subtest appears to be the most biased of the performance measures on the *WAIS-R*. Often a performance profile for an Indian client will show a significant deficit for the PA (e.g., mean scale score for all performance subtests 8, PA scale score 2). Some aspect of temporal or social awareness and subsequent sequencing may not be totally understood by traditional clients. Unfamiliarity with many of the pictures is another reason why there may be a deficit on this subtest. It is often necessary to prorate without the PA score to obtain a nonverbal I.Q. score.

Block Design. An Indian client's score on the Block Design subtest usually correlates very well with the client's score on Raven's *Progressive Matrices.* Relatively strong correlations for the Block Design and performance I.Q. are noted in the *WAIS-R* manual (Wechsler, 1982). It is very helpful to watch the trial and error procedures used by Indian clients in taking this subtest. Block Design is often the high-point performance subtest noted and is a relatively good measure of general cognitive functioning.

Object Assembly. The Object Assembly subtest is another good measure of nonverbal constructional skills. It is also a good measure of trial-and error procedures and frustration tolerance. As with many non-Anglo populations, occasionally a client will not recognize the subjects of some of the more difficult puzzles.

Digit Symbol. The Digit Symbol subtest emphasizes motor speed as well as accuracy. Occasionally, Indian clients, like Anglo clients, will attempt more quality in responses at the expense of quantity. The need for speed should be addressed since some more traditional Indian clients will sacrifice time for accuracy if the directions are not clarified. In general, however, this particular subtest does not seem to be significantly biased.

In addition to the performance subtest measures, we often utilize the Digit Span subtest administered in the Indian client's native language. It is often useful to compare their Digit Span forward and reverse scores in both their native language and English. The Similarities subtest can also be used due to its relatively simple stimulus words and brief responses format. Indian clients often do well on this subtest; many answers are high quality responses since they are often associated with nature (e.g., things that are alive, parts of nature, human resources, etc.). In general, we report both the *WAIS-R* performance I.Q. score and the individual's total *Raven* score and percentile. Occasionally, an Indian client will be somewhat tense or anxious during face-to-face interaction with the examiner during the administration of the *WAIS-R.* When this is observed, more emphasis may be placed on *Raven's Progressive Matrices* in order to allow the individual the benefit of nonface-to-face completion of a cognitive test. Once again, the examiner must be alert for any signs of problems which may contraindicate the use of certain test procedures.

Additional tests which are relatively nonbiased in obtaining cognitive functioning levels of American Indians include selected subtests from the *Wechsler Memory Scale-Revised* and the *McCarron-Dial Perceptual Memory Survey,* as well as many neuropsychological test procedures. It helps to emphasize the qualitative and process responses of American Indian clients as opposed to the product (e.g., a specific intellectual quotient or standard score). Standarized scores and performance I.Q. scores and percentiles can be used (cautiously) for certain placement purposes (Social Security Disability, job placement purposes, etc.). Test data should be collected routinely to use in the local norming of standardized test procedures. This helps to provide a reference point for cognitive as well as personality evaluation devices. It helps to get into the habit of compiling individual client data on computer as it becomes available to the clinician. Providing inservice training workshops to Indian counselors and the consumers of psychological reports provides for continuity of service and partial elimination of misunderstanding in the use of tests.

Rorschach. Once some degree of cognitive assessment has been conducted, it is useful to move on to personality assessment. A number of test procedures are useful in this regard. Perhaps one of the most misunderstood and overlooked, but potentially useful, measures of personality functioning is the *Rorschach Test.* Considerable research has been conducted on this device in the past fifteen years which has provided a firm empirical base including impressive data with respect to validity and reliability (Exner, 1986). According to Exner, the process of formulating and delivering *Rorschach* responses is essentially identical across experiential backgrounds, and thus, the interpretations derived from the instrument are applicable to most individuals able to provide a sufficiently long and complex (i.e., valid) record. We have found this to be true of the American Indian population in Arizona based on assessments of over 350 Navajo, Hopi, and Apache clients.

The advantages of the *Rorschach* for the American Indian population include its relatively simple, nonthreatening, and untimed administration procedure, and its avoidance of any need for reading or writing skills. The primary disadvantage for its use with this group involves its demand for verbal responses from clients who may exhibit linguistic deficits or oral hesitancy. In our experience, however, valid records are the rule rather than the exception. Certain normative defferences must, however, be understood for valid interpretation to follow once the record is obtained.

In interpretation of the *Rorschach,* it is important to distinguish between clients who have had significant off-reservation or urban experience (off-R) and those who have remained principally on-reservation (on-R). Those in the off-R category generally provide records quite similar to the published norms (an average of 22 responses) and inclusion in this category can generally be confirmed by near-average performance on the Information subtest of the *WAIS-R* or *WISC-R* (scaled score greater than 6) provided the performance I.Q. is within the average range. For clients with limited urban or Anglo-cultural experience, obtained records will, on the average, be shorter (an average of 18 responses). The standard prompt when the client gives only one percept on Plate I (e.g., "I'm sure you can find more than one thing") will in most cases be necessary. According to P. Erdberg (personal communication, Jan. 1, 1989), Exner recommends that when a client gives single responses to plates II-V, the examiner should return to Plate I and say "Now I want you to tell me more things that you see." This method will often produce a more adequate record.

Preliminary analysis of one hundred Rorschach protocols by the authors over the past ten years suggest that "popular" responses are, with few exceptions (Plates VII, IX, and X), delivered with a frequency similar to published normative data, and the popular count (P) may be confidently used as a reflection of conventional perceptual processes. Form quality (FQ) is directly comparable to published data as a useful measure of reality testing. An elevated Lambda ($L > 3.0$) is quite common and usually can be interpreted directly as a measure of level of psychological complexity. Lambda can also vary with respect to the off-R and on-R groups, the former generally being lower. Interpretation of color responses (FC/CF + C) and the affective ratio may follow directly from published information, though lower obtained values in both regards should be expected. The movement score (M) is, in this population, equally indicative of

distrubed interpersonal relationships and distorted thinking as it is in the Anglo population.

Generally, *Rorschach* interpretation for this special population is quite similar to that for Anglo culture. It certainly provides more reliable information on personality than the *Minnesota Multiphasic Personality Inventory (MMPI)* and other similar paper-and-pencil tests.

Thematic Apperception Test. The *TAT* is a device often used in the process of personality assessment, but its usefulness is strongly tied to the verbal fluency of the client. The confounding cultural and linguistic variables involved in the administration and interpretation of this device renders it of limited value in the routine assessment of American Indian clients. In many cases, it might yield rich descriptive information concerning cultural factors, but its power to discriminate idiosyncratic personality variables from cultural/enviornmental influences is rather poor. Highly verbal clients may respond quite well, but caution is required to proceed confidently with interpretation.

Other Tests. Additional tests which are helpful in certain individual cases include the *Beck Depression Inventory* (either administered orally or in written form, depending on the client's reading level), the *Suicide Probability Scale* and the *Western Personality Inventory*. All of these tests can be useful in individual cases when rehabilitation program planning is a primary goal. The *MMPI* and *MMPI-II* are not recommended for use with Indian clients unless they are very highly acculturated to mainstream Anglo society. They are too time-consuming and many of the questions are misinterpreted by American Indian clients. Psychological evaluations where the *MMPI* has been used with traditional American Indian clients tend to show clinical elevations on such scales as the SC, SI, and PD triad. These elevations have been found to be due, in part, to the client's misunderstanding of the stimulus questions (e.g., double negatives). Culutral factors also influence responses.

Of prime concern in the use of personality tests is the information one wishes to obtain that, for the most part, cannot be obtained through clinical interviewing. For example, if an individual admits to depression or the referral agent suggests this possibility, and a specific etiology or cause for depression cannot be linked to precipitating factors, then it may be useful to administer some type of paper-and-pencil test. The *Beck Depression Inventory* can help in differentiating major depression from an adjustment disorder. Caution is necessary in using this instrument, particularly since it requires a certain level of English comprehension and general reading skills. Standardized test procedures can also help in determining reasons for excessive drinking behavior. If these reasons cannot be gleaned from the clinical interview, the *Western Personality Inventory* can be useful for exploring issues such as alienation or aloneness, depressive fluctuations, and related issues underlying drinking. If answers cannot be obtained through interviewing, then perhaps more formal assessment might help.

Up to this point, assessment devices have been discussed in regard to formulating a working hypothesis of a particular Indian client's cognitive functioning and emotional status. In addition to assessment of functional limitations, strengths/weaknesses, and prognosis, some test procedures have been found to be effective in measuring ongoing benefits from therapy.

The *Draw-A-Person (DAP)* test and the *Bender Visual Motor Gestalt Test (BVMGT)* are helpful in this regard, particularly with chronic mentally ill American Indian clients. One often sees a change in the complexity of drawings towards more normalization as progress in therapy continues.

Summary

It cannot be emphasized enough that there are many important considerations for the evaluation process with members of any ethnic minority group. It is of critical importance when dealing with American Indian clients not only to have knowledge of appropriate testing techniques, but also a fair degree of experience before one is fully competent to utilize evaluations for critical decisions regarding program eligibility, hospital commitment, etc. The examiner should provide the client with an initial orientation, be careful to have a nonthreatening appearance, and be culturally sensitive during the evaluation. It helps to maintain a sense of humor, avoid exaggerating the importance of the tests during the evaluation, and provide generous and friendly feedback and interpersonal interaction with the client.

Psychological evaluation with American Indians is still a very cautious business. One can overinterpret, misinterpret, or underinterpret important data which can influence the life of the client. Much research, many case studies, and the development of practical applications for testing and evaluation are needed to further advance the field and the quality of services provided to American Indians. While the state of the art in terms of the psychological evaluation of American Indians may still "not look too good," it is, however, continuing to show development and improvement.

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